CRISIS EXCEPTION CRITERIA CHECKLIST

Customer Name: _____ **CME:** _____ **Date:** _____

TCM Name: _____ **Fax #:** _____ **Phone #:** _____

Is the customer transferring to HCBS/FE from the Money Follows the Person Grant Program (this question is not applicable for those transferring from the MFP State Program)?	☐ Yes (Move to Comprehensive Support and/or Sleep Cycle Support Questions)	☐ No (Continue to Oral Health and Preliminary Questions)

Oral Health Questions: ☐ Requesting ☐ Not needed	**(A)**	**(B)**
(1) Did the customer have a treatment plan in place prior to 1/1/2010?	☐ Yes	☐ No
What point is the dentist at in working with the customer on the total oral procedure/plan?		
(2) Does the customer require emergency treatment to resolve an oral health issue that is life threatening?	☐ Yes	☐ No
(3) How will non-treatment of the oral health issue impact the customer?		

Preliminary Questions for Assistive Technology, Comprehensive Support, and Sleep Cycle Support:	**(A)**	**(B)**
(1) Does customer have family or friends within a close proximity to provide daily informal supports?	☐ No	☐ Yes
(2) Has there been an APS confirmation of self-neglect or abuse?	☐ Yes	☐ No
(3) Is the customer isolated or live alone?	☐ Yes	☐ No
(4) Does the customer have a cognitive impairment?	☐ Yes	☐ No
If yes, what is the severity of the cognitive impairment?		
(5) Is the customer in the end stages of an illness and receiving Hospice Care?	☐ Yes	☐ No
(6) Did the customer score a "4" in toileting, transferring, medication management/treatment, and walking/mobility?	☐ Yes	☐ No
CRISIS EXCEPTION – Go on to the next sections and answer the questions linked with the services the customer is in need of receiving.		

Assistive Technology Questions: ☐ Requesting ☐ Not needed	**(A)**	**(B)**
(1) Does the customer meet (A) in Preliminary Question #1?	☐ Yes	☐ No
(2) Does the customer meet (A) in Preliminary Question #3?	☐ Yes	☐ No
(3) Has the customer had surgery in the last 30 days that resulted in a loss of functional ability or mobility?	☐ Yes	☐ No
Surgery must have been due to stroke, broken hip, or other medical incident/justification. Please provide the reason for surgery:		
(4) Is the customer being discharged from NF/Hospital/Rehab?	☐ Yes	☐ No
(5) Is the Assistive Technology required in the first 30 days of discharge to the community?	☐ Yes	☐ No
What item(s) or modification will be requested on the Assistive Technology Request Worksheet?		

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Comprehensive Support Questions: ☐ Requesting ☐ Not needed	**(A)**	**(B)**
(1) Is the customer a MFP Grant Program transfer?	☐ Yes	☐ No
(2) Is the customer in the end stages of Alzheimer's?	☐ Yes	☐ No
(3) Does the customer suffer from a brain injury with memory loss?	☐ Yes	☐ No
(4) Does the customer require supervision for elopement that is likely to result in danger to self?	☐ Yes	☐ No

Sleep Cycle Support Questions: ☐ Requesting ☐ Not needed	**(A)**	**(B)**
(1) Is the customer a MFP Grant Program transfer?	☐ Yes	☐ No
(2) Does the customer have a documented health and welfare need? (Health and welfare need would include bedridden and requiring assistance with turning or toileting, or certain medical interventions)	☐ Yes	☐ No
Please specify the health and welfare need: _____		
What medical intervention is needed? _____		

NARRATIVE SECTION: (Required)

please give description of customer's current situation and reasoning for request of service(s)

_____
_____
_____
_____
_____
_____
_____
_____
_____

KDOA DETERMINATION:

Customer is approved for a crisis exception: ☐ Yes ☐ No

Crisis exception granted for the following service(s):

☐ Assistive Technology ☐ Comprehensive Support ☐ Oral Health ☐ Sleep Cycle Support

MMIS claims for Oral Health Services:

Date crisis exception processed: _____

Comments: